CONFIDENTIAL

Transcultural Care
Olamide Alabi, DNP, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655 & 210 East Main St, Suite C Tupelo MS 38804
Phone 662 234 5317 Fax 662 269 6089
Email: info@transcultural-care.com

Patient Registration Information

Last Name: _____First Name: _____Middle Initial: _____

Preferred Name: _____SSN _____ DOB: ___/____/_____ Gender: M ___ F ___ Other ___

Address: _____City: _____State:____Zip:_____

Mailing Address (If Different Than Above): _____

Mobile Phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Place of Employment: _____ Please circle one: Full time Part time

Pharmacy _____: Address _____ City_____State: ___ Zip: _____

Patient's Email Address: _____

Primary Care Provider: _____ Phone: _____

Who were you referred by? _____

Emergency Contact: _____ Emergency Contact Phone: _____

Emergency Contact Relation: _____

Last Name: _____First Name: _____Middle Initial: ____

Relationship to patient: _____

DOB _____ Driver's License _____State_____

Address: _____City_____State_____Zip_____

I acknowledge that I have received a copy of Transcultural Care's Privacy Practices (otherwise known as HIPPA).
Patient name or guardian/parent: _____ Date: _____

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Insurance information:

Please bring your insurance card(s) and ID to your first appointment. The primary insurance is usually based on the earliest birthday of the subscribers.

Primary Insurance. _____

Customer Service Phone Number: _____

Place of Employment: _____

Subscriber/Member Name (if other than patient): _____

DOB: _____ **SS#**_____

Subscriber Id # _____ Group/Policy # _____

Relationship To Patient/Patient: _____

Please check with your insurance company to find out your benefits and responsibilities, including if you have a deductible and the amount of your co-pay.
Please be prepared to pay your co-pay and deductible (if applicable) at the time of the visit. We accept cash, checks, all major credit cards, and HSA/FSA cards.

Deductible (if applicable) _____ New Deductible begins _____

Co-pay or Co-insurance_____

I authorize Transcultural Care LLC to bill my insurance company as well as release any information needed to do so and assign benefits Transcultural Care LLC.
Printed Name: _____ Signature: _____ Date: _____

Responsible party (If Under 18): _____

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Financial Responsibility:

Please provide the following credit card information. **PLEASE NOTE**: This information must be completed. All information is kept confidential and will only be used for missed appointments or to clear up any outstanding balance (over 60 days past due).

Credit Card Number: _____

Exp. Date: _____ CVV Code (3-digit code printed on back of card): _____

Zip Code for the Debit/Credit Card listed above: _____

Name (as printed on card): _____

Patient Signature: _____ Date: _____

Please read carefully and initial each of the following: By signing this form, I am authorizing Transcultural Care LLC, to charge my credit card in the event I fail to show for a scheduled appointment or if I do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance. I am aware that weekends and holidays do not count as normal business hours (appointments on Monday must be cancelled by the Friday before). I understand there will be a fee of $100.00 for each missed follow-up appointment and a fee of $250.00 if I miss my initial intake appointment. I am aware that my insurance will not cover a missed appointment and that I am responsible for this fee. I understand and agree that my card may be charged without me being present. I will not dispute for sessions that I have received or for sessions I have cancelled less than 24 business hours in advance. Initial: _____
If I arrive more than 10 minutes late to an appointment it will be considered a late cancellation / missed appointment and I will be rescheduled for another time. Initial: _____

I further understand that I am responsible for updating my billing information, including changes to my address, credit card information, and insurance information, in the event that this information should change. I understand I am responsible for any fees incurred for a declined credit card transaction. I acknowledge that I am aware there is a $35.00 fee for any declined credit card charge or returned check. Initial: _____

Balances past due for 90 days will be sent to an outside collections' agency. Initial: _____

My co-pay, co-insurance, and deductible (when applicable) are due at my appointment time by cash, check, or card (credit/HSA/FSA). I am aware that any balances over 30 days may incur a 1.5% monthly finance charge (18% per annum) and that there is a $5.00 billing fee per appointment, per cycle. It is understood that despite my means of payment at my appointment time, my credit card account will be charged for any outstanding balance over two months (60 days) if there is no response to the statements that are sent monthly. Initial: _____

Printed Name: _____ Signature: _____ Date: _____

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Confidentiality and Informed Consent for Treatment

Clinical records are confidential. Information about your treatment will not be released without your written permission with a few exceptions. Nurse Practitioners are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse, and evidence of past, or current elder abuse. Confidentiality may also be broken if the information could help save your life in a life-threatening emergency. Information may also be shared with medical providers who are concurrently providing medical treatment for you to promote coordination of care and the benefit to you of shared knowledge.

For your protection, digital communication through unsecured means is kept to a minimum. We utilize the OnPatient portal which is a secure, fully encrypted platform that will allow you to send/receive direct messages, access your health record, and schedule appointments. **Please use the OnPatient portal to ask any clinical questions rather than email. A registration link for OnPatient will be sent to you once you are scheduled. This is the best way to reach me if you have any questions.** If you do not wish to use the OnPatient portal, then please call the office telephone number, but it may take longer to receive a response. In either case, it may take 2-3 business days for a response. Please notify the office if you have any difficulties with accessing the portal.

You should know that sometimes during treatment, symptoms become worse before they become better, though this should subside as the work of treatment progresses. You may be asked to have laboratory work or EKG screens done outside of this office, or I may ask that records and test results from your PCP be sent to me. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. You have the right to withdraw from treatment at any time or to ask to be referred to someone else.

You have the right to be informed of your mental health diagnosis after the mental health assessment is completed, and the purpose of any prescribed medication and their potential side effects. We will discuss risks, benefits, and alternatives. You should understand that some medications require a taper to avoid potentially uncomfortable discontinuation syndrome. Continued prescription of medications requires periodic reviews in the office where I can assess how you are doing and if the medication needs to be, or should be, continued. It is important for you to know that medications do not work for everyone.

Please determine who will be involved in your treatment and initial for each:

Name	Relationship	Phone:	Initial
	Primary care provider (PCP)		
	Therapist		
	Family Member		
	Other:		

My signature below indicates that I have read the above information and am requesting mental health treatment from Olamide Alabi, DNP, PMHNP-BC

Patient signature: _____ Date: _____

Parent/guardian signature (for patients under 18): _____ Date: _____

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Patient Policy Agreement – Please read each section carefully. Sign and date at the bottom.
These policies as well as our Privacy policy can also be found on our website - http://www.transcultural-care.com

1. Services are provided with the understanding that **you** (not an insurance company) are ultimately responsible for the cost of the services that you are purchasing. Insurance plans vary and not all services may be covered. You are responsible for knowing what services are covered by your particular plan, please check with your plan by calling the number on the back of your card **before** your appointment. If your need prior authorization for services, this must be completed before you are scheduled.

2. If your insurance does not pay your claim, it will be your responsibility to contact them to resolve any issues of coverage or coordination of co-coverage. If you have a change in your insurance, it is your responsibility to notify the office as soon as possible to ensure that the correct company is being billed and that your account does not become past due.

3. The person signing below is the account guarantor and is accepting responsibility to pay for services rendered. This includes those provided to a child - regardless of custodial or legal agreements between parents.

4. Payment for deductibles, co-pays, uncovered services, or any balance due on your account are to be paid at the time of your – or your child's – appointment. Please come, or send your child, prepared to do so. If you are not in a financial position to pay at the time of the appointment, we will be happy to reschedule the appointment for a more convenient time.

5. Accounts with unpaid balances over 90 days past the date of service will be given to an outside collection agency to bill and collect. An additional fee will be added to cover the expenses involved to do so. Your insurance will not pay for these additional charges.

6. If 12 months has passed since you were last seen, you will no longer be considered an established patient with us due to you not following up within the agreed upon amount of time.

7. Prescriptions will be written with enough refills to last until your next appointment. We recommend scheduling your next appointment at the end of each session so that we can be sure you are following your treatment plan and also do not run out of medication. My strict policies primarily reflect my concern for my clients' well-being. Self-assessment of psychiatric symptoms can be difficult and requires quite a bit of practice and feedback, especially early in treatment.

9. **Medication refills are done during the appointment time only.** If something unexpected occurs, please have your pharmacy fax a refill request. Do not email or call about refills. Please allow up to **5 business days** for the refill to be approved, if appropriate, and schedule an appointment as soon as possible.

10. Controlled substances such as benzodiazepines and stimulants are tightly regulated by the DEA. These medications can be very useful when indicated, but require more monitoring and must be part of a comprehensive treatment plan. If you do not adhere to the agreed upon treatment plan, then I will be unable to continue to provide care to you. There will be no early refills of controlled substances for any reason.

Patient name: _____ Date _____

Patient/Guarantor signature & relationship _____ Date _____

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Initial visit health history form

Patient's name: _____ **Date of birth**: _____ **Date:** _____

In a few sentences, please tell me what is bothering you and how long this problem has been going on:

_____

Was there a recent change or situation that convinced you to make this appointment?

_____

Have you ever been treated before by a mental health specialist (therapist, nurse practitioner, psychiatrist, psychologist)?

If so, please list their name and city/state._____

Are you seeing any of these professionals currently? Which ones _____

Is it okay if I contact any of these people to obtain records? _____

Have you ever considered or attempted suicide? If so when and how? _____

_____

Been hospitalized for mental health reasons? If so, when, where, and why? _____

_____

Had violent behavior toward another person? Please describe circumstances: _____

_____

Does anyone in your family have a history of mental health issues? If so, please specify the condition and their relationship to you: _____

Are you currently ☐ working ☐ student ☐ unemployed ☐ disabled ☐ retired

What is/was your occupation? _____

Who are you currently living with? _____

Highest level of education you have achieved: _____

Are you receiving or applying for FMLA or any form of short-term disability? Please be aware that you need to be seen at least three times before the provider will fill out any related documents and we cannot complete documents related to long-term disability.

☐ Yes, I am receiving currently ☐ I am in the process of applying and understand the policy ☐ No

Are you currently: ☐ married ☐ partnered ☐ divorced ☐ single ☐ widowed

Please list any allergies or reactions to any medications (example: Penicillin itchy rash):

_____

Please list all prescription medications being taken currently, why, and who is prescribing it.

Past psychiatric medications: If you have ever taken any of the following medications, please write the approximate dates, dose, how helpful they were, and any side effects (if you cannot remember, just do your best):

Antidepressants

Amitriptyline (Elavil)	Emsam (selegiline)	Pamelor (nortriptyline)	Sinequan (Doxepin)
Anafranil (clomipramine)	Lexapro (escitalopram)	Paxil (paroxetine)	Trintellix (vortioxetine)
Celexa (citalopram)	Luvox (fluvoxamine)	Pristiq (desvenlafaxine)	Viibryd (vilazodone)
Cymbalta (duloxetine)	Nardil (phenelzine)	Prozac (fluoxetine)	Wellbutrin (bupropion)
Effexor (venlafaxine)	Norpramin (desipramine)	Remeron (mirtazapine)	Zoloft (sertraline)

Mood stabilizers

Depakote (valproate)	Lithium (lithium carbonate)	Topamax (topiramate)	
Lamictal (lamotrigine)	Tegretol (carbamazepine)	Trileptal (oxcarbazepine)	

Antipsychotics/mood stabilizers

Abilify (aripiprazole)	Haldol (haloperidol)	Risperdal (risperidone)	Zyprexa (olanzapine)
Clozaril (clozapine)	Latuda (lurasidone)	Saphris (asenapine)	
Geodon (ziprasidone)	Rexulti (brexpiprazole)	Seroquel (quetiapine)	

Sedatives/hypnotics

Ambien (zolpidem)	Desyrel (trazodone)	Restoril (temazepam)	Sonata (zaleplon)
Belsomra (suvorexant)	Lunesta (eszopiclone)	Rozerem (ramelteon)	

Anxiety medications

Ativan (lorazepam)	Kapvay (clonidine)	Neurontin (gabapentin)	Xanax (alprazolam)
Buspar (buspirone)	Klonopin (clonazepam)	Valium (diazepam)	
Inderal (propranolol)	Minipress (prazosin)	Vistaril (hydroxyzine)	

ADHD medications

Adderall XR (amphetamine)	Strattera (atomoxetine)	Intuniv (guanfacine)	
Ritalin (methylphenidate)	Concerta (methylphenidate)		
Vyvanse (lisdexamfetamine)	Kapvay (clonidine)		

Other psychiatric medications taken not mentioned above:

_____

Over the counter medications, herbs, supplements, or vitamins being taken:

_____

Do you follow any particular diet? _____

The last time blood was drawn for laboratory tests? _____ Who ordered it? _____

Why? _____ Were any of the tests abnormal?_____

_____

Who is your primary care provider (PCP)? _____

For women only: Are you nursing, pregnant, or planning on becoming pregnant? ☐ yes ☐ no

Are you using any birth control or contraception? Which? _____

Review of physical health

Do you have any of the following symptoms? If so, please highlight or circle:

General: weakness, fatigue, fever or chills, weight gain, weight loss, increased appetite, decreased appetite

Head ears nose throat: headache, head injury, lightheadedness, vision changes, hearing problems, tinnitus, vertigo, nasal stuffiness, nasal discharge, nosebleeds, sinus trouble, dry mouth, hoarseness

Cardiac: chest pain or discomfort, palpitations, rapid heartbeat, dizziness with position changes, shortness of breath, fainting, swelling in feet/legs

Respiratory: dry cough, productive cough, shortness of breath, wheezing

Gastrointestinal: heartburn, nausea, diarrhea, constipation, abdominal pain, rectal bleeding

Skin: acne, rash, wounds, skin discoloration

Urinary: frequent urination, pain with urination, difficulty fully emptying bladder, incontinence

Sexual health: painful intercourse, difficulty achieving orgasm, low libido, excessive libido, erectile dysfunction

Neurological: seizure, migraine, dizziness, tremor, numbness, tingling

Musculoskeletal: new or worsened muscle pain, new or worsened joint pain, stiffness, involuntary movements

Is your medical provider (PCP) aware of the above issues? ☐ yes ☐ no

History of high blood pressure? _____ High cholesterol? _____ Heart mummer? _____

Irregular heartbeats? _____ Any other heart related concerns? Please specify

_____

History of kidney disease? _____

Lung or breathing difficulties? (e.g., asthma.) _____

History of problems with the thyroid? _____

Problems with blood sugar?_____

Any surgeries? If so what and when?_____

Any other health concerns or history of problems not asked about above? _____

_____

Any unusual or significant medical conditions in blood relatives? _____

_____

Mental health

If you drink caffeine, how many drinks per day? (coffee, tea, energy drinks, soda): _____

If you drink alcohol, what is the most number of alcoholic drinks you'll drink per day? (1 drink is 12oz of beer, 1.5oz of spirits, or 5oz glass of wine): _____ How many days per week do you drink? _____

If you smoke marijuana, how often? _____

Do you use any other substances? How often? (meth, heroin, LSD, non-prescribed medications, etc.) _____

_____

Do you think you may have a problem with alcohol or drug use? ☐ yes ☐ no

Have you ever received treatment for alcohol or substance abuse? ☐ yes ☐ no

If yes, for which substances? _____

Where were you treated and when? _____

_____

Check once for any symptom currently present ✓ Check twice for major symptoms that are very bothersome ✓✓

☐ Depressed mood ☐ Anxiety ☐ Excessive worry ☐ Panic attacks ☐ Difficulty concentrating

☐ Excessive energy ☐ Hallucinations ☐ Decreased need for sleep ☐ Irritability ☐ Issues sleeping

Have you **ever** had feelings or thoughts that you did not want to live? ☐ yes ☐ no

Do you **currently** feel that you do not want to live? ☐ yes ☐ no

I own or have access to firearms ☐ yes ☐ no If yes, is the weapon properly secured? ☐ yes ☐ no

Do you have a history of legal problems? (DUI, domestic violence, arrests, prison, etc.) ☐ yes ☐ no

_____

Do you have or think you have ADHD/ADD? ☐ yes ☐ no

If you were diagnosed with ADHD/ADD, how old were you? _____

Are/were you a survivor of any form of abuse?

Physical abuse ☐ yes ☐ no age of occurrence _____

Sexual abuse ☐ yes ☐ no age of occurrence _____

Emotional abuse ☐ yes ☐ no age of occurrence _____

I feel safe at home and in my relationships ☐ yes ☐ no

What are some activities that help you feel peaceful, content, or relaxed? _____

Please list at least 2 people that you feel you can count on if you are having a difficult time:

_____

Is there anything else that you feel is worth mentioning? _____

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RELEASE OF INFORMATION

Patient's name: _____ Date of birth: _____

Information may be disclosed to or obtained from:

_____

Specifically, I authorize the exchange of the following confidential information by my **initials**:

_____ Mental health treatment information

_____ Drug/alcohol treatment information

_____ History/physical exam, and laboratory results

_____ Other _____

I understand that any of the above requested information may include results of substance abuse and/or diagnosis and treatment of mental health disorders.

I understand that I can revoke this authorization at any time by providing a written letter of my intent to revoke but that revoking it will not affect disclosures made before the revocation letter is received. This consent shall expire in one (1) year following the end of treatment.

Patient's printed name _____

Patient signature _____ Date _____

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TELEPSYCHIATRY INFORMED CONSENT

Patient Name: _____

Location of Patient: _____ **Date of Birth** _____

Introduction:

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interface such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect confidentiality of patient identification. Imaging data and other protected health information will be protected through measures that safeguard data and ensure the integrity against intentional or unintentional corruption.

Expected Benefits:

1. Improved access to psychiatric care by allowing the patient to remain in the home or office and in a geographical location that serves to be in the patient's best interest to remain due to restrictions in travel.
2. More efficient psychiatric evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are risk associated with telepsychiatry. These risks include but are not limited to:

In rare case, information transmitted may not be sufficient due to poor resolution to allow for appropriate medical decision making by the tele psychiatrist and client.'

Delays in medical evaluation and treatment could occur due to failure of equipment.

In some cases, there may be a lack of access to complete medical records, resulting in adverse drug reactions or allergic reactions as well as other judgmental errors.

Alternative Options:

There are available appointments to have face-to-face encounter visits in an office setting at the physical location of Transcultural Care and when consent is obtained for telepsychiatry, the client is agreeing to obtain telepsychiatry services.

Please initial you have read this page regarding benefits, risks, and alternative options: _____

Telepsychiatry Policies

Transcultural Care: Telepsychiatry Protocol

1. Telepsychiatry cannot provide any provision of medical or psychiatric emergencies. In the case of emergency, patients are encouraged to seek local help or call 911.
2. Patients who receive telepsychiatry services must be seen in person at least once a year.
3. New Patient consultations are done in person and telepsychiatry encounters are for follow up appointments
4. Guidelines generally considered standard for keeping medical records, release of information, and patient confidentially will be applied to telepsychiatry as well.
5. No recording of session is allowed in any circumstances. Patients need to notify the psychiatric provider if another person is present in the session.
6. After initial evaluation or anytime during treatment the psychiatric provider may recommend local psychiatric services, if patients need are judged to be not met through telepsychiatry or if other clinical grounds exist. Every effort will be made to provide local referrals.

7. Medication fills and refills can only be made after the session and is subjected and limited to local pharmacy's guidelines, limitations, and policies. Prescribing controlled medications will have higher level of scrutiny and will be solely at the discretion of the tele psychiatrist based on clinical needs.
8. No shows and late cancellations of less than 24 hours of appointment time will be charged as the same rate as regular in-office appointments.
9. All payments will be made before the sessions.

I agree with the policies outlined above

Patient's Name: _____

Patient's Signature: _____

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of tele-psychiatry which identified me will be disclosed to researcher and other entities about my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of tele-psychiatry in the course of my care at any time, without affecting my rate and future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telepsychiatry interaction, and may receive copies of this information for reasonable fee.
4. I understand that a variety of alternative methods of psychiatric care may be available to me, and I may choose one or more of these at any time.
5. I understand that is is my duty to inform my psychiatric provider of any other healthcare providers in my medical/psychiatric care.
6. I understand that I may expect anticipated benefits from the use of telepsychiatry in my care, but then the results can be guaranteed or assured.

7. Patient Consent to the Use of Telepsychiatry

8. I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatric provider or such assistance of may be designated, and all of my questions have been answered to my satisfaction. I hereby giving informed consent for the use of telepsychiatry and my medical use.
9. I hereby authorize _____ to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient: _____ *Date* _____

If Authorized Signer: _____ *Date* _____

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I, _____, UNDERSTAND AND AGREE TO THE FOLLOWING CONDITIONS REGARDING TREATMENT WITH TRANSCULTURAL CARE, LLC:

1. An initial evaluation will be completed to review all symptoms, medications, medical and family history. I am aware that psychological testing may be deemed necessary for some patients along with ADHD screening scales that may warrant completion by the patient or outside sources. I understand that this evaluation does not guarantee a diagnosis of ADHD, nor will there be a prescription written until all studies listed below are completed. A determination will be made and discussed during the evaluation.

2. I understand that if risk factors are identified, an electrocardiogram (EKG) or cardiac consult may be indicated to determine a baseline for overall heart function. This may need to be performed annually based on the initial results and/or an as needed basis. Some patients will need to complete these tests and consultations prior to starting medications.

3. All follow up appointments scheduled must be attended, and medication refills cannot be obtained without an appointment or approval from the provider. Replacement prescriptions will not be given for lost or stolen scripts, and the patient must have a follow up appointment. If medications are stolen, a police report must be filed and returned to the office to be included in the file.

4. Urine drug screen will be required from time to time.

5. The Mississippi Prescription Monitoring Program (PMP) is assessed prior to initial evaluation and at each visit, to verify prescriptive history. Medication for ADHD can only be obtained from a single provider. Refills can only be written for 30 days at a time. Refills beyond a 30 day supply will be dated for the earliest fill date.

6. If currently prescribed benzodiazepines, it is the policy of the practice that assistance may be provided (at the discretion of the provider) in tapering off these medications with the option of substituting with the other non-addictive/non benzo type medications. This will be further discussed during the appointment.

By signing below, I indicated that I agree with all of the terms set forth above

Patient Signature: _____Print Name: _____ Date_____

Parent Signature: (if patient is a minor) _____ Print Name_____ Date_____

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Buprenorphine & Controlled Substance Treatment Agreement

I _____agree to accept the following treatment contract for buprenorphine office-based opioid addiction treatment:

1. I will keep my medication in a safe and secure place away from children (e.g., in a lock box). My plan is to store it (describe where and in what)? _____

2. I will take the medication exactly as my doctor prescribes. If I want to change my medication dose, I will speak with the doctor first. Taking more than my doctor prescribes or taking it more than once daily as my doctor prescribes is medication misuse and may result in supervised dosing at the clinic. Taking the medication by snorting or by injection is also medication misuse and may result in supervised dosing at the clinic, referral to a higher level of care, or change in medication based on the doctor's evaluation.

3. I will be on time to my appointments and be respectful to the office staff and other patients.

4. I will keep my doctor informed of all my medications (including herbs and vitamins) and medical problems.

5. I agree not to obtain or take prescription opioid medications prescribed by any other doctor.

6. If I am going to have a medical procedure that will cause pain, I will let my doctor know in advance so that my pain will be adequately treated.

7. If I miss an appointment or lose my medication, I understand that I will not get more medication until my next office visit. I may also have to start having supervised buprenorphine dosing.

8. If I come to the office intoxicated, I understand that the doctor will not see me, and I will not receive more medication until the next office visit. I may also have to start having supervised buprenorphine dosing.

9. I understand that it is illegal to give away or sell my medication – this is diversion. If I do this, my treatment will no longer include unsupervised buprenorphine dosing and may require referral to a high level of care, supervised dosing at our clinic, and/or a change in medication based on the doctor's evaluation.

10. Violence, threatening language or behavior, or participation in any illegal activity at the office will result in treatment termination from our clinic.

11. I understand that random urine drug testing is a treatment requirement. If I do not provide a urine sample, it will count as a positive drug test.

12. I understand that I will be called at random times to bring my medication bottle into the office for a pill count. Missing medication doses could result in requirement for supervised dosing or referral to a higher level of care at this clinic or potentially at another treatment provider based on your individual needs.

13. I understand that initially I will have weekly office visits until I am stable. I will get a prescription for 7 days of medication at each visit.

14. I can be seen every two weeks in the office starting the second month of treatment if I have two negative urine drug tests in a row. I will then get a prescription for 14 days of medication at each visit.

15. I will go back to weekly visits if I have a positive drug test. I can go back to visits every two weeks when I have two negative drug tests in a row again.

16. I may be seen less than every two weeks based on goals made by me and my doctor.

17. I understand that people have died by mixing buprenorphine with other drugs like alcohol and benzodiazepines (drugs like Valium®, Klonopin® and Xanax®).

18. I understand that treatment of opioid addiction involves more than just taking my medication. I agree to comply with my doctor's recommendations for additional counseling and/or for help with other problems.

19. I understand that there is no fixed time for being on buprenorphine and that the goal of treatment is to stop using all illicit drugs and become successful in all aspects of my life.

20. I understand that I may experience opioid withdrawal symptoms when I go off buprenorphine.

21. I have been educated about the other two FDA-approved medications for opioid dependence treatment, methadone and naltrexone.

22. If female, I have been educated about the increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment and offered methods for preventing pregnancy.

23. If female, I have been educated about the effects of poor diet, illicit opioid use, use of dirty needles/sharing injection equipment, physical and mental trauma, and lack of pre-natal medical, substance use and mental health care during pregnancy and how these things can adversely affect my health and my current or future fetus/newborn's health. I understand that neonatal abstinence syndrome can occur when taking illicit opioids and that neonatal abstinence syndrome (NAS) is less severe, but can still occur, when pregnant women take methadone or buprenorphine as prescribed/dispensed in substance use disorder treatment. Cigarette smoking can make the severity of NAS worse and cause pre-term birth and small babies. Alcohol use can cause significant cognitive/brain damage in fetuses and newborns.

PRINT NAME	SIGNATURE	DATE

Transcultural Care
Olamide Alabi, DNP, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 269 6089
Email: info@transcultural-care.com

Substance Use History

	No	Yes/Past/Now	Route	How Much	How Often	Quantity	Date/Time Last Use
Alcohol							
Caffeine							
Crystal Meth							
Ecstasy							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Sleeping pills							
Tranquilizers							
Other							

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FOLLOW UP VISIT FOR SUBOXONE

Name: _____ DOB: _____ Date: _____

SYMPTOMS (please circle one)

Stable: _____ Worse: _____ Improved: _____ Unchanged: _____

Have you had any cravings? (please circle)

NO: _____ YES: (explain) _____

_____

Since your last visit, have you relapsed? (if yes please specify which substance and when)

NO: _____ YES: (explain) _____

_____

Have you attended AA/NA meetings since your last visit? (if yes dates and location)

NO: _____ YES: (explain) _____

_____

Have you established a support network? (family, non-drug using friends, spouse, significant other)

NO: _____ YES: (explain) _____

Authorization to Leave Personal Health Information by Alternative Means this includes information pertaining to Drug, Alcohol & Psychiatric Conditions

Patient Name: _____ DOB: _____

Patient Mailing Address: _____

Please fill all that apply:

May leave/share message on voicemail at home # (_____) _____
May leave/share message with spouse (name) _____
May leave/share info with other family (name) _____
May call or text detailed message on cell phone # (_____) _____
May leave/share detailed message at a different # (_____) _____
May send message to this email address _____